

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i></i>	Last <i>Chalupa</i>	4. DATE OF DEATH Month <i>Nov</i>	Doy <i>30</i>	Year <i>1958</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5 July 1925</i>	9. AGE (In years last birthday) <i>33</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Mittenwald, Poland</i>	12. CITIZEN OF WHAT COUNTRY? <i>Krak-Polish</i>
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13. FATHER'S NAME <i>Wasyl Chalupa</i>	14. MOTHER'S MAIDEN NAME <i>ANNA Jawarnicka</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>219-34-8885</i>	17. INFORMANT <i>Mrs. John Chalupa, Huntingtown, Md.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Address
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of neck</i>	INTERVAL BETWEEN ONSET AND DEATH
816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) " skull auto accident	

MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto collision</i>		
20c. TIME OF INJURY Month, Day, Year How o. m. p. m. <i>11/30/58</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/> <i>at road</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Sunderland Cal. Md</i>	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE <i>G. J. Weems</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) <i>G. J. Weems</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-2-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Our Lady Star of the Sea</i>	22d. LOCATION (City, town, or county) <i>Solomons</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home</i>	ADDRESS <i>1201 E. Main St.</i>	24a. REC'D BY REGISTRAR <i>REC</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Knue</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

EXAMINER'S CERTIFICATE OF SERVICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12291

12290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 1	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby, Md.		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rachael Lee Chase	Middle 	Last 	4. DATE OF DEATH November 18	Month 11	Day 18	Year 1958

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1958	9. AGE (In years lost birthday) yrs. 9 17	IF UNDER 1 YEAR Months 9	Days 17	IF UNDER 24 HRS. Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		

13. FATHER'S NAME James Chase		14. MOTHER'S MAIDEN NAME Minnie Johnson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Minnie Chase, Lusby, Md.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE George J. Weems		Huntingtown, Md.
PHYSICIAN'S NAME (Type) Dr. George J. Weems		

22a. BURIAL OR CREMATION: REMOVAL (Specify) 11-20 58	22b. DATE THEREOF 11-20 58	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns	22d. LOCATION (City, town, or county) Lusby
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23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sowell Prince Frederick	ADDRESS 2064245 X V4	24a. REC'D BY REGISTRAR NOV 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
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WYOMING STATE DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

Mr. John D. Smith
John D. Smith
11-22-39

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12292

12291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Charles</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb <i>Private residence</i>		d. STREET ADDRESS <i>Bel Alton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Closed Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>Archie</i>
4. DATE OF DEATH		Month <i>Nov</i>	Day <i>7</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3/13/71</i>		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Self Emp.</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Fowler</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>NONE.</i>		17. INFORMANT <i>Henry Fowler, Bel Alton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cardio vascular cerebral disease 3 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pedal edema for two years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 8, 1957</i> , to <i>Nov 11, 1958</i> , that I last saw the deceased alive on <i>Nov 11, 1958</i> , and that death occurred at <i>Bel Alton</i> , M.D., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H.W. Ward</i>		ADDRESS (Street, city or town, state) <i>Owings, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 10, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Ignatious Church Cemetery, Chapel Point, Maryland</i>
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Funeral Home, Inc.</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>NOV 12 '58</i>		AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1851

RECORDED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Prince Frederick (Rural)</i>		d. STREET ADDRESS <i>—</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>C</i>	Middle <i>Wesley</i>	Last <i>Hall</i>	4. DATE OF DEATH Month <i>Nov.</i>	Day <i>5</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>July 16 1882</i>	9. AGE (In years last birthday) yrs. <i>76</i>	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTH PLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. S.A.</i>	
13. FATHER'S NAME <i>Thomas Hall</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Hutchins</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-36-4703</i>		17. INFORMANT <i>Edward Hall - Prince Frederick, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>722.0</i> DUE TO <i>Adrenal Insufficiency</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>2 months,</i>							
(b) DUE TO <i>Ch. Rheumatoïd Arthritis</i> <i>20 years</i>							
(c) DUE TO <i>Steroid Therapy</i> <i>4 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 1958, to <i>Nov 5</i> , 1958, that I last saw the deceased alive on <i>Nov 5</i> , 1958, and that death occurred at <i>Prince Frederick</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Peter Jett</i> M.D. ADDRESS (Street, city or town, state) <i>Prince Frederick</i> DATE SIGNED <i>1958</i>							
PHYSICIAN'S NAME (Type) <i>Peter C. Jett</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 8, 1958</i> 22b. DATE THEREOF <i>Asbury Cemetery</i> 22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury Cemetery</i> 22d. LOCATION (City, town, or county) (State) <i>Burton, Calvert Co., Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.O. Hobbes Son Funeral Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

VERMONT STATE DEPARTMENT OF LEGAL - JOURNAL

CERTIFICATE OF DEATH

MARSHALL

CLARK

CLARK, MARSHALL, died at his residence, 123 Main Street, on the 1st day of January, 1900, aged 65 years, 1 month, 10 days.

He was born at Middlebury, Vermont, on the 1st day of April, 1834, and resided in Middlebury until he was 18 years of age, when he moved to Middlebury, Vermont, where he resided until his death.

CLARK

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
8M 2/57

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12293 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12294

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Calvert</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Calvert</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Breazy Point</i>	c. LENGTH OF STAY IN lb <i>80A.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cal Co Hosp</i>	e. STREET ADDRESS <i>Bertha E. Hubacher</i>					
3. NAME OF DECEASED (Type or print) <i>Bertha E. Hubacher</i>	4. DATE OF DEATH Month <i>Nov</i> Day <i>30</i> Year <i>1958</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>16 July 1888</i>	9. AGE (In years from birthday) <i>70</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>King W Figgins</i>	14. MOTHER'S MAIDEN NAME <i>Ella Anders</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>578-05-4825</i>	17. INFORMANT <i>Sam Hubacher</i> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> none						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Southland</i>	(County) <i>Maryland</i>	(State) <i>8</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <i>G. J. Weems</i>						
ACTUAL SIGNATURE <i>G. J. Weems</i>	DATE SIGNED <i>30 Nov 1958</i>					
EXAMINER'S NAME (Type) <i>G. J. Weems</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 3rd - 58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Southland</i>	(State) <i>Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemmons Brothers</i>	ADDRESS <i>1661-9d Hazel Rd</i>	24a. REC'D BY REGISTRAR <i>REC 3 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John L. Pease</i>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12295

CERTIFICATE OF DEATH

12294

Reg. Dist. No.....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Calvert CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Prince Frederick HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>		MARYLAND LENGTH OF STAY (in this place) 1 day STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lusby STREET ADDRESS <i>(If rural give location)</i>	
3. NAME OF DECEASED (First) Lydia (Middle) _____ (Last) _____		4. DATE OF DEATH November 15 19 58	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH November 9, 1866
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Sauserman		14. MOTHER'S MAIDEN NAME Catherine Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. no	17. INFORMANT & ADDRESS Mrs. Nathaniel Sollers, Lusby, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) <i>Arteria.</i> ANTECEDENT CAUSE(S) DUE TO <i>Hypertensive C.V.R.</i>			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/13 , 19 58 , to 11/15 , 19 58 , that I last saw the deceased alive on 11/15 , 19 58 , and that death occurred at 3 P.M. from the causes and on the date stated above. SIGNATURE <i>W. Deems</i> ADDRESS (Street, city, town, state) Huntingtown, Maryland DATE SIGNED 11/15/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 18, 1958	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL Community Church Cemetery - Lusby - Calvert Co. - Md.	
REGISTRAR'S SIGNATURE <i>Arthur E. Deems</i>		LOCATION (City, town, or county) Community Church Cemetery - Lusby - Calvert Co. - Md.	
DATE NOV 18 '58		25. FUNERAL DIRECTOR'S SIGNATURE A. O. Harkness & Son - Funeral, Md.	
ADDRESS			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12296

12295

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Calvert
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First James	Middle David	Last McNamara	4. DATE OF DEATH Month November Day 11 Year 58	19

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1887	9. AGE (in years last birthday) yrs. 71	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal Railroad Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? USA						

13. FATHER'S NAME John McNamara	14. MOTHER'S MAIDEN NAME Sarah Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Margaret McNamara, North Beach, Md.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Coronary Occlusion.
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 1/20/58 , 19 58 , to 1/11/58 , 19 58 , that I last saw the deceased alive on 1/10/58 , 19 58 , and that death occurred at Huntingtown , M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Huntingtown					
ACTUAL SIGNATURE H. Weems	M.D.	DATE SIGNED 1/11/58			
PHYSICIAN'S NAME (Type) George J. Weems, M. D.	Huntingtown, Md.				

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/13/58	22b. DATE THEREOF 1/13/58	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) Huntingtown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros. 1661-9d Hope St.	ADDRESS Summers Bros. 1661-9d Hope St.	24a. REC'D BY REGISTRAR DATE NOV 12 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	Date of Death
John Doe		1900-01-01	1950-01-01
Place of Death			
Hospital			
Cause of Death			
Diseases present			
Other conditions			
Name and address of physician			
Signature of physician			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12296

CERTIFICATE OF DEATH

Reg. Dist. No.

12297

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		c. LENGTH OF STAY IN 1b RURAL and give nearest town Lower Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Perry's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MAMIE	Middle E.	Last SHECKLELLS
4. DATE OF DEATH	Month Nov.	Day 8	Year 58
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 1, 1880
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William T. Jones		14. MOTHER'S MAIDEN NAME Mary E. Norfolk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or date of service]		16. SOCIAL SECURITY NO. - - -	17. INFORMANT Mrs. Andrew Grover Address Owings, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10/5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gradual weakened with kidney		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall from bed	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify, that I attended the deceased from Jan 1, 1958 to 11/18, 1958 , that I last saw the deceased alive on 11/8, 1958 , and that death occurred on 11/18, 1958 , from the causes and on the date stated above. ACTUAL SIGNATURE H. W. Ward		ADDRESS (Street, city or town, state) Owings DATE SIGNED Nov 11/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1958	22c. NAME OF CEMETERY OR CREMATORIUM All Saints Cemetery
22d. LOCATION (City, town, or county) Sunderland		(State) maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home		24a. REC'D. BY REGISTRAR DATE NOV 13 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Traas.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - DEATH CERTIFICATE

NAME OF DECEASED	ADDRESS	NAME OF DOCTOR	NAME OF HOSPITAL
AGE	SEX	CAUSE OF DEATH	TIME OF DEATH
DATE OF BIRTH	DATE OF DEATH	TIME OF DEATH	TIME OF DEATH
DEATH CERTIFIED			
IN THE PRESENCE OF			
SIGNED AND SWEARED			

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Oxford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>H. Beach</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>11 Beach Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Stanley Jerome Studwart</i>		First <i>S</i>	Middle <i>J</i>
4. DATE OF DEATH <i>Oct 7, 1958</i>		Month <i>10</i>	Day <i>9</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct 7, 1958</i>		9. AGE (In years from birthday) yrs. <i>11</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>	
13. FATHER'S NAME <i>James Fudd Studwart</i>		14. MOTHER'S MAIDEN NAME <i>Kellie Zephew</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>475X</i>		16. SOCIAL SECURITY NO. <i>7 Studwart H. Beach Md</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Upper respiratory disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found dead in bed at 8 AM</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>While at work</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Address</i>
20f. (City or town) <i>Owings</i>		(County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>11/9/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 10, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Harmony Cemetery</i>		22d. LOCATION (City, town, or county) <i>Near Owings, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Owings, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Date Nov 13 '58</i>	

WISCONSIN STATE BOARD OF NURSING - CERTIFICATE OF TITLE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. MCGOWAN
AGE: 65
SEX: MALE
MATERIAL TESTED: BLOOD

DEATH CERTIFICATE NUMBER: 1234567890
DEATH DATE: NOVEMBER 12, 1988

EXAMINER'S SIGNATURE: JOHN J. MCGOWAN
EXAMINER'S LICENSE NUMBER: 1234567890

EXAMINER'S ADDRESS: 1234 WISCONSIN AVENUE, MILWAUKEE, WI 53204

EXAMINER'S PHONE NUMBER: (414) 555-1234

EXAMINER'S FAX NUMBER: (414) 555-1234

EXAMINER'S E-MAIL ADDRESS: JOHN.MCGOWAN@WISNURSES.WI.GOV

EXAMINER'S SPECIALTY: MEDICAL EXAMINER

EXAMINER'S STATE BOARD OF NURSING CERTIFICATE NUMBER: 1234567890

EXAMINER'S MEDICAL EXAMINER'S CERTIFICATE NUMBER: 1234567890

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12298

CERTIFICATE OF DEATH

Reg. Dist. No.

12299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Calvert County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake Beach		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward		First Edward	Middle 	Lost Teague	4. DATE OF DEATH 11 28 1958	Month 11	Day 28	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/96	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Force		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jefferson Teague		14. MOTHER'S MAIDEN NAME Lilly Mae Oxford							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War I & II		16. SOCIAL SECURITY NO. 		17. INFORMANT Wade L. Teague, Randle Cliff, Md.		Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 10 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Coronary Artery Disease							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) (State)	
21. I certify that I attended the deceased from Oct 1st, 1958 to Nov 28, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at , M, from the causes and on the date stated above. ACTUAL SIGNATURE Page C. Jett M.D. Prince Frederick, Md. DATE SIGNED 11/28/58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12- 2-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Ft Myer, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DEC 2 30		24b. REGISTRAR'S SIGNATURE John W. Smith			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12299

CERTIFICATE OF DEATH

12300

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Huntingtown</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
3. NAME OF DECEASED (Type or print) <i>Marvin</i>		First <i>Stanley</i>	Middle <i>Wallace</i>
4. DATE OF DEATH <i>November 17 1958</i>		Month <i>November</i>	Day <i>17</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>September 2, 1958</i>		9. AGE (In years last birthday) <i>3 months</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>3</i> Days <i>15</i> Hours <i>00</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Irene Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>James Wallace, Huntingtown</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute tracheo-bronchitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>two days</i>	
DUE TO <i>500X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/17</i> , 19 <i>58</i> , to <i>11/17</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/17</i> , 19 <i>58</i> , and that death occurred at <i>Prince Frederick, Md.</i> ADDRESS (Street, city or town, state)		DATE SIGNED <i>11/17/58</i>	
ACTUAL SIGNATURE <i>Dr. Page C. Jett</i>		M.D. <i>Dr. Page C. Jett</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Page C. Jett</i>			
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-18-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Pelham</i>
22d. LOCATION (City, town, or county) <i>Huntingtown, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Sewell Prince Fred, Md.</i>		ADDRESS <i>2064378XV4</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 25 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Curious S. Krause</i>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BALTIMORE 38

CERTIFICATE OF DEATH

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